# Arizona Early Intervention Program
# HEARING SCREEN TRACKING FORM

Child's Name: _____ Date of Birth: _____

Screener: _____ Date: _____

Birth Hospital: _____ Mother's Maiden Name:_____

## REVIEW OF MEDICAL RECORDS:

### Previous Hearing Screening

Newborn Hearing Screening
**Right** ☐ Pass ☐ Refer **Left** ☐ Pass ☐ Refer
Date:_____

Outpatient or Other Hearing Screen
**Right** ☐ Pass ☐ Refer **Left** ☐ Pass ☐ Refer
Date: _____

### Previous Hearing Evaluation

☐ Yes ☐ No Does this child have a diagnosed permanent hearing loss in both ears?

☐ Yes ☐ No IF YES – Has the family been referred to the Arizona State Schools for the Deaf and the Blind Parent Outreach Program

### Risk Indicators for Late Onset or Progressive Hearing Losses

__ Parental/ caregiver concern about speech or hearing
__ Family history of permanent childhood hearing loss.
__ Postnatal infections including bacterial meningitis.
__ Head trauma.
__ Recurrent/ persistent otitis media for at least 3 months.
__ Stigmata associated with hearing loss.
__ In-utero infections such as cytomegalovirus, herpes, rubella, syphilis and toxoplasmosis.
__ Neonatal indicators-specifically hyberbilirubinemia, or persistent pulmonary hypertension.
__ Syndromes associated with progressive hearing loss.
__ Neurodegenerative disorders.

### Guidelines For AzEIP Hearing Screening

No Hearing Screening Necessary if:

□ Child passed newborn or other objective hearing screening within the past six months

**and**

□ Child has **no** risk indicators for late onset or progressive hearing loss.

## RESULTS OF INITIAL AzEIP HEARING SCREENING:

### Visual Inspection:

Date:_____
**Right** ☐ Pass ☐ Refer **Left** ☐ Pass ☐ Refer

### Otoacoustic Emissions (OAE) Screening Results

Date: _____
**Right** ☐ Pass ☐ Refer or Could not test
**Left** ☐ Pass ☐ Refer or Could not test

### *Tympanometry/Reflectometry Screening Results

**Right** ☐ Pass ☐ Refer or Could not test
**Left** ☐ Pass ☐ Refer or Could not test

**Comments**:_____

_____

*If possible, a child who does not pass the initial AzEIP hearing screening should receive a follow-up hearing screening within 2-4 weeks, prior to making a referral.*

### Results of Second AzEIP Hearing Screening:

### Visual Inspection:

Date:_____
**Right** ☐ Pass ☐ Refer **Left** ☐ Pass ☐ Refer

### Otoacoustic Emissions (OAE) Screening Results

Date: _____
**Right** ☐ Pass ☐ Refer or Could not test
**Left** ☐ Pass ☐ Refer or Could not test

### *Tympanometry/Reflectometry Screening Results

**Right** ☐ Pass ☐ Refer or Could not test
**Left** ☐ Pass ☐ Refer or Could not test

**Comments**:_____

_____

### Referrals

☐ *If OAE=refer and Tymp/ Reflectometry=pass then obtain medical referral for pediatric audiology evaluation within 2-4 weeks.*

☐ *If OAE=refer and Tymp/ Reflectometry=refer or not available then the child should receive a medical evaluation of the middle ear and an evaluation by a pediatric audiologist to rule out hearing loss.*

**** if available***

# Arizona Early Intervention Program
# HEARING SCREENING REFERRAL FORM

Child's Name: _____ Date of Birth: _____

Screener: _____ Date: _____

Birth Hospital: _____ Mother's Maiden Name:_____

| How does OAE screening help to identify young children who may be at risk for hearing loss? | |
|---|---|
| Children will not pass the OAE screening if the:<br>▪ Ear canal is blocked with wax or debris;<br>▪ Middle ear structure is abnormal or filled with fluid;<br>▪ Cochlea is not responding to sound. | OAE screening identifies children who may have a<br>▪ Fluctuating loss associated with otitis media;<br>▪ Permanent loss associated with physical abnormalities of the middle or inner ear. |
| OAE screening is <u>not</u> synonymous with audiological assessment and children who refer on repeated OAE screening attempts should receive prompt medical and/or audiological follow-up. | |

**Dear Medical Provider:**

**This child is being referred to you because he/she did not pass Otoacoustic Emissions (OAE) hearing screening in one or both ears and may have a hearing loss. Your assistance is needed to assess this child's middle ear status and obtain referrals and authorizations for a pediatric audiological evaluation for possible hearing loss.**

Date: (___/___/___) Name of Medical Provider: _____

***Diagnosis:*** ☐ Normal Exam ☐Cerumen ☐ Middle ear disorder (describe): _____

☐ Other: _____

***Follow-up Recommendation(s) and date by which recommendation should be completed:*** (check all that apply)

☐ Audiological evaluation (___/___/___) Referral to_____

☐ Referral to ENT or other specialist (___/___/___) Referral to_____

☐ Repeat hearing screening (___/___/___)

☐ Medical treatment (___/___/___) (describe)_____

☐ Other _____ (___/___/___)

***Please complete this form and return to:***

**Name:** _____ **Address:** _____

**Fax:** _____ **Phone:** _____

***The completed form should be returned as soon as the initial evaluation is completed, but no later than 4 weeks from the date of referral.***